Rapid resolution of social anxiety disorder, selective mutism, and separation anxiety with paroxetine in an 8-year-old girl

Social anxiety disorder (SAD) causes intense fear of being judged negatively in a social situation.[1,2] Selective mutism may be a symptom of SAD, rather than a distinct diagnostic syndrome. In a study of 30 children with selective mutism, 97% were diagnosed with SAD.[3] Because SAD onset in early childhood often predicts nonrecovery in adulthood,[4,5] long-term detrimental outcomes may be prevented by early diagnosis and treatment of SAD in young children.

Selective serotonin reuptake inhibitors (SSRIs) are a logical first-choice treatment of selective mutism in children because of the relation between selective mutism and anxiety disorders, the general failure of nonpharmacologic therapies to produce significant changes in speech patterns and the chronic nature of mutism and its effect on social and academic functioning.[6,7] Furthermore, SSRIs are effective for the treatment of obsessive–compulsive disorder and major depression in children, as well as for SADs in adults.[8] Previous research has demonstrated the efficacy of fluoxetine, sertraline and fluvoxamine in the treatment of selective mutism and anxiety disorders.[6–9] We report the case of a child diagnosed with SAD and selective mutism who successfully responded to paroxetine treatment.

The patient was an 8-year-old girl who was diagnosed before 1 year of age with significant separation anxiety. Although some degree of separation anxiety is expected in young children, the anxiety exhibited by this patient at 7–8 months of age far exceeded that normally expected in children of this age. Her anxiety was so profound that her parents were unable to leave her with a sitter even for a brief period.

SAD and selective mutism were identified by 5 years of age via structured interviews with her parents; the child refused to speak to the psychiatrist. In retrospect, however, symptoms were present from the early stages of verbal development. The patient spoke to no one other than her parents and siblings, even refusing to speak to her grandparents, and she did not speak outside the home. Symptoms included mild-to-moderate obsessive–compulsive ideations, multiple physical complaints and gastrointestinal distress. She frequently complained of feeling sick and would perseverate on the fear of separation from her family and interactions with other people. The effects of SAD and selective mutism were especially problematic outside the home, causing the patient to often be late or absent from school. She would express separation anxiety when away from her mother and made frequent phone calls to determine her mother's whereabouts. The patient would also isolate herself from outdoor activities and friends and required her mother's presence in bed to fall asleep. Despite her difficulties with attendance, she was able to maintain good academic grades.

The patient tolerated paroxetine, 5 mg once daily at bedtime, with no adverse effects. No behavioural therapies were initiated in conjunction with the paroxetine medication regimen. Her parents and teachers reported a rapid, positive response (within 2–3 weeks), with dramatic improvements in all aspects of social skills. She no longer experiences selective mutism. She attends school on a regular and timely basis without distress and is able to play outdoors and socialize with friends. The patient is able to go to bed by herself and no longer demonstrates separation anxiety. She participated in a theatrical summer camp and was able to perform onstage. Her teachers describe her as an excellent student who is social and talkative, and they report that she has made incredible progress in oral participation and written work.

SAD and selective mutism are often dismissed as shyness, misdiagnosed or simply overlooked in children. However, early recognition, diagnosis and treatment of SAD may prevent adverse outcomes and the development of comorbid conditions for the patient later in life. It is believed that familial factors and history can significantly contribute to and affect treatment outcomes. Additionally, results from a previous study in which the relation between childhood separation anxiety disorder and DSM-III-R anxiety disorders in adulthood was examined suggests that childhood separation anxiety disorder may be a noteworthy, predeterminant risk factor for multiple anxiety syndromes in adulthood.[10] The fact that this

young girl had such a positive response to treatment with paroxetine may have reduced her risk for continued anxiety syndromes in adulthood.

Previous research has found SSRIs to be safe and effective for the treatment of selective mutism and anxiety disorders in children.[6–9] The results of studies with children were consistent with those of studies in adults with anxiety disorders, as well as with studies of SSRIs in children with obsessive–compulsive disorder and major depression.[9]

This case indicates that paroxetine is an effective and well-tolerated treatment for SAD and selective mutism in this child. Within a 2- to 3-week period, the patient experienced total recovery of selective mutism and made noted progress in the number of episodes and severity of anxiety attacks and symptoms associated with SAD. These improvements have been constant for 3 years, and the patient remains on paroxetine, 5 mg once daily at bedtime. The patient's dosage will be reduced at the end of her next academic year to determine if continued pharmacotherapy is still required.

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